



# National Route of Registration

Registration Application Booklet for  
Registration as a Pharmacist under Section 14  
and Section 16(1) of the Pharmacy Act 2007 –  
National Route

Pharmaceutical Society of Ireland  
PSI House  
Fenian Street  
Dublin 2  
IRELAND

Tel: + 353 1 2184000 Fax: + 353 1 2837678 Email: [info@PSi.ie](mailto:info@PSi.ie)



## CHECK LIST



PSI House, Fenian Street, Dublin 2  
Telephone: + 353 1 2184000  
Facsimile: + 353 1 2837678  
Email: [registration@thepsi.ie](mailto:registration@thepsi.ie)  
Web: [www.thepsi.ie](http://www.thepsi.ie)

Please complete this form in BLOCK CAPITALS using a black pen. ALL parts of this application MUST be completed INCLUDING the checklist.

Checklist – please check to ensure that you have enclosed the following items with your application		Please cross
1	A completed application form and the non-refundable fee of €540.00	
2	A photocopy of your birth certificate issued by country of birth ( <i>include original translation where appropriate</i> ) and marriage certificate ( <i>include original translation if appropriate</i> )	
3	A photocopy of your passport ( <i>include original translation where appropriate</i> )	
4	A photocopy of your pharmacy degree certificate	
5	Evidence you have completed your internship and passed the Professional Registration Examination	
6	A completed Photo Form with two recent photographs	
7	A completed Health Status Form	
8	A completed Statutory Declaration Form	
9	Please note the following “ <i>in accordance with the Data Protection Acts 1988-2003, all personal information provided by you will be treated in the strictest confidence and kept secure at all times. The PSI does not release any information you provide to third parties except in accordance with legislative requirements and in accordance with the PSI - Public Registers Terms and Conditions or as set out in the PSI's Registration with the Data Protection Commissioner</i> ”	

Please also check that you have <b>not</b>		Please cross
1	Included any original documents(except the application, health status, statutory declaration & photo form)	
2	Included any document or item which you need to be returned	

For PSI use only

Date Stamp

Registration Reference Number:

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## REGISTRATION APPLICATION FORM – National Route of Registration



### Form of Application for Registration

*(in accordance with Sections 14(1) and 16(1) of the Pharmacy Act 2007 and the Pharmaceutical Society of Ireland (Registration) 2008 Rules (SI 494 of 2008)*

**Explanatory Note:** Please complete ALL PAGES and ALL SECTIONS of this form. Please complete the form in ink using block capital letters. ***Please note that incomplete and/or incorrect forms will be considered invalid and will be returned to applicants.***

#### Section 1: Personal & Contact Information

I \_\_\_\_\_ (Name of applicant in full as on birth certificate/marriage certificate or passport, where appropriate) hereby apply to register as a pharmacist.

Residential Address:

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Practice Address (address at which you intend to practice as a pharmacist, if known):

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Country & Place of Birth:

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Date of Birth:

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Nationality:

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Contact Telephone Number:

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Mobile Telephone Number:

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Email Address (print legibly):

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## REGISTRATION APPLICATION FORM – National Route of Registration

### Section 2: Details of Formal Qualifications in Pharmacy

Titles of Qualifications in Pharmacy	Name and Address of Awarding Body	Degree Programme Start Date	Degree Programme Completion Date

### Section 3(a): Details of In-service Training leading to Entitlement to practice Pharmacy\*

*\*this relates to formal supervised in-service training completed as discrete continuous period where no period is less than 6 months. Periods of vacation work not leading to the award of the entitlement to practise pharmacy should not be included.*

Date Started:	Date Finished:	Name & Address of Premises:	Area of Practice: (community, hospital, industry, academic)	Average No. of Hours worked per week:	Total No. of Months training completed:

## REGISTRATION APPLICATION FORM – National Route of Registration

### Section 3 (b): Professional Registration Examination

I have satisfactorily completed all the components of the requisite 12 months in-service practical training as per Rules 14 (2) and 18 (1) of Pharmaceutical Society of Ireland (Education & Training) Rules 2008

Yes

☐

I have successfully completed the Professional Registration Examination

Yes

☐

Proof of completion of internship programme (evidence accepted includes one of the following **MPharm cert: PRE results: letter from College**)

Yes

☐

### Section 4: Details of Professional Practice/Professional Standing & Good Character/Reputation

#### PRACTICE AS A PHARMACIST

HAVE YOU EVER BEEN REGISTERED/ENTITLED TO PRACTISE PHARMACY IN ANY **OTHER** COUNTRY?

Yes

☐

No

☐

If **YES**, state the country(ies): \_\_\_\_\_

ARE YOU OR HAVE YOU BEEN SANCTIONED RESTRICTED OR PROHIBITED IN CONNECTION WITH PRACTISING AS A PHARMACIST OR OPERATING A PHARMACY IN ANY COUNTRY/STATE/REGION?

Yes

☐

No

☐

If **YES**, please complete the following:

Name of Country/ State / Region	Circumstances of the sanction connected with your practise as a pharmacist/entitlement to operate a pharmacy	Penalty/Sanction imposed

#### PRACTICE AS ANOTHER HEALTH OR SOCIAL CARE PROFESSIONAL

ARE YOU/HAVE YOU EVER BEEN QUALIFIED/ENTITLED TO PRACTISE ANOTHER HEALTH (INCLUDING ANIMAL HEALTH) OR SOCIAL CARE PROFESSION?

Yes

☐

No

☐

If **YES**, state the name of the profession(s): \_\_\_\_\_

ARE YOU OR HAVE YOU EVER BEEN SANCTIONED, RESTRICTED OR PROHIBITED FROM PRACTISING OR CARRYING ON, ANY OTHER PRACTICE, PROFESSION OR OCCUPATION WHICH CONSISTS OF HEALTH (INCLUDING ANIMAL HEALTH) OR SOCIAL CARE?

Yes

☐

No

☐

## REGISTRATION APPLICATION FORM – National Route of Registration

If **YES**, please complete the following:

Name of Country/State/ Region (including Ireland)	Circumstances of the sanction connected with the practise or carrying on of any practice, profession or occupation which consists of the provision of health care (including animal health) or social care services?	Penalty/Sanction imposed

### PRACTICE AS A NON HEALTH RELATED PROFESSIONAL

ARE YOU OR HAVE YOU EVER BEEN SANCTIONED, RESTRICTED OR PROHIBITED FROM PRACTISING  
OR CARRYING ON, ANY OTHER PRACTICE, PROFESSION OR OCCUPATION **OTHER THAN** HEALTH  
(INCLUDING ANIMAL HEALTH) OR SOCIAL CARE?

Yes

☐

No

☐

If **YES**, please complete the following:

Name of Country/State/ Region (including Ireland)	Circumstances of the sanction connected with the practise or carrying on of any practice, profession or occupation which consists of the provision of health care (including animal health) or social care services?	Penalty/Sanction imposed

### CONVICTIONS

HAVE YOU EVER BEEN CONVICTED OF AN OFFENCE IN ANY COUNTRY/STATE/REGION

Yes

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No

☐

If **YES**, please complete the following:

Name of Country/State/ Region (including Ireland)	Nature of Offence	Penalty/Sanction imposed

## REGISTRATION APPLICATION FORM – National Route of Registration

## Section 5: Work &amp; Educational History since completing Leaving Certificate (or other final Secondary School Examination)

Title of Final Secondary School Examination completed (*or equivalent*): \_\_\_\_\_

Year of completion of Final Secondary School Examination: \_\_\_\_\_

Country in which Final Secondary School Examination Completed: \_\_\_\_\_

Summary of Education, Training & Work Experience <u>relevant to Pharmacy</u> since completing Final Secondary School Examination [PLEASE DO NOT INCLUDE DETAILS ALREADY PROVIDED IN PART 3(a)]			
Year	Nature of Education undertaken OR work experience gained	Place & Country in which Education was obtained/Work experience undertaken	Full/Part-time (provide details of hours per week)

## REGISTRATION APPLICATION FORM – National Route of Registration

### Section 6: Confirmations

#### I CONFIRM THAT:

- |       |   |                          |
|-------|---|--------------------------|
| (i)   | I understand that, save as is hereinafter provided, the Pharmaceutical Society of Ireland (PSI) will not discuss my application for registration with persons other than myself. I authorise the PSI to communicate as necessary with appropriate third parties to verify my application or any aspect thereof or any document accompanying same.                                       | <input type="checkbox"/> |
| (ii)  | I understand that the submission of false, incorrect or fraudulent information in this application or the omission of relevant information from this application will be viewed very serious by the Council of the PSI and may result in this application being invalidated and my name being erased subsequently from the Register of Pharmacists in Ireland.                          | <input type="checkbox"/> |
| (iii) | I understand and accept that the law does not permit me to practise as a pharmacist, carry out the duties of a pharmacist otherwise than under the supervision of a registered pharmacist, or represent myself as a pharmacist, until my name has been entered in the Register of Pharmacists in Ireland.   | <input type="checkbox"/> |
| (iv)  | I understand and accept that a sufficient level of competence in the Irish or English language(s) is necessary to work safely, communicate effectively with patients, health professionals and others and to discharge the professional activities of a pharmacist in order that patients are at all times protected and I hereby confirm that I have the level of competence required. | <input type="checkbox"/> |
| (v)   | I am not aware of any reason, on grounds of physical or mental health, why I might be unable to discharge the responsibilities of a registered pharmacist, which I understand, may include taking sole charge of a community or hospital pharmacy.  | <input type="checkbox"/> |
| (vi)  | I am not the subject of any legal or disciplinary proceedings in Ireland, or in any other country   | <input type="checkbox"/> |

### Section 7: Declaration

**I declare** that I have completed this application form fully and that the information provided on this form, is to the best of my knowledge, complete and correct.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Witness<sup>1</sup>: \_\_\_\_\_

Date: \_\_\_\_\_

Name/Address of Witness: \_\_\_\_\_

<sup>1</sup> This declaration may be witnessed by any individual known to you



## PHOTO FORM



### SUBMISSION OF PHOTOGRAPH

For the purposes of applications to register under S.14(1) and S.16(1) of the Pharmacy Act 2007 (as amended)

FIRST NAME:

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SURNAME:

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**Please provide two recent passport photographs. Sign and date this form and return with all documentation accompanying the application to register.**

I confirm that:

1. The two photographs I have provided here are recently taken ones of me.
2. I have printed my name in block capitals on the reverse side of each photograph.
3. A registered legal or healthcare professional has signed and dated both photographs, and certified that the photograph is a photograph of me and is a true likeness.
4. I am submitting these photographs and confirmation for the purposes of my application for registration as a pharmacist under sections 14(1) and 16(1) of the Pharmacy Act 2007 (as amended)

Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

I certify that the two photographs signed and dated by me are photographs of the applicant, and are true likenesses of the applicant.

Witnessed by<sup>2</sup>:

\_\_\_\_\_

Name:

(Signature)

Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Registering Body of Witness: \_\_\_\_\_

Registration No. of Witness: \_\_\_\_\_

<sup>2</sup> The registered Legal or Healthcare professional who has signed and dated both photographs

Please

Attach

Photo

Here

## HEALTH STATUS FORM - [for the purposes of registration as a pharmacist]



### DECLARATION BY APPLICANT

(to be signed by the applicant in the presence of the registered medical practitioner)

I, the undersigned, wish to undergo a medical examination for the purposes of obtaining registration as a pharmacist, which may include taking sole charge of a community or hospital pharmacy

Name of Applicant:

(Name in full as it appears on the Birth / Marriage Certificate)

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Of:

(Address of Applicant)


Date of Birth:

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Signed:

(Signature of Applicant)

Date:

### MEDICAL PRACTITIONER CERTIFICATION

**TO:** The Registrar, Pharmaceutical Society of Ireland, PSI House, Fenian Street, Dublin 2, Ireland

**I, THE UNDERSIGNED REGISTERED MEDICAL PRACTITIONER, HEREBY CERTIFY THAT:-**

- The applicant has signed the above declaration in my presence
- I have examined the applicant with regard to his/her physical and mental health

**My opinion as to the state of the applicant's physical or mental health is as follows:-**

The examination did not disclose any reason on grounds of physical or mental health why he/she should not be able to discharge the responsibilities of a registered pharmacist.

Yes

☐

No

☐

If **No** – state reasons below-


Signed:

(Signature of Medical Practitioner)

Date:

Print Name:

Registration Number:

Practice Address:

Telephone:

Official Surgery Stamp

## **STATUTORY DECLARATION FORM**

To be completed in the presence of a Notary Public / Commissioner for Oaths/Peace Commissioner/Practising Solicitor



IN THE MATTER OF PART 4 OF THE PHARMACY ACT 2007

AND

IN THE MATTER OF PART 3 AND SCHEDULE 1 OF THE PHARMACEUTICAL SOCIETY OF IRELAND (REGISTRATION) RULES 2008 (SI. 494 of 2008)

AND

IN THE MATTER OF AN APPLICATION BY

*[Insert the name of the applicant here]:*


TO HAVE THEIR APPLICATION FOR REGISTRATION AS A PHARMACIST CONSIDERED FOR PRACTICE IN THE STATE

I, \_\_\_\_\_  
*[insert name of applicant here]*

Of \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
*[insert your usual residential address here]*

do solemnly and sincerely declare as follows:

I, \_\_\_\_\_ *[insert your name here]*, am one and the same person as the applicant in the Form of Application for registration as a pharmacist to which this declaration relates.

1. All the information provided by me in the said application form is, to the best of my knowledge, information and belief, true, accurate, correct and complete.
2. The copies of my birth certificate, my current passport (and if applicable my marriage certificate) which accompany my said application are true copies of the original documents which are themselves authentic.
3. The facts dates and circumstances contained within all the copy certificates and documents presented are, to my knowledge, true and accurate.

## **STATUTORY DECLARATION FORM**

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4. The passport sized photograph which I have provided as part of this application represents a true current likeness of me the declarant.
5. The copy of my pharmacy degree, and evidence that I have passed the Professional Registration Examination, which accompany my application form, are true copies of the originals, which are authentic documents.
6. Insofar as there is any difference between my name as it appears in the said Form of Application and/or in this declaration and/or in the various documents which accompany same I say that I am one and the same person as the person mentioned therein and I will if called upon so to do by Pharmaceutical Society of Ireland (PSI) provide further evidence to that effect.
7. I consider that I have sufficient competence in the English, or Irish language, necessary to discharge my professional obligations as a pharmacist.
8. If it is considered that I do not have sufficient competence in the English, or Irish language, necessary to discharge my professional obligations as a pharmacist, I attest that I will undertake to acquire this competence.
9. I declare that I am aware of the legal, moral and ethical principles which govern the profession of pharmacist in the State and that I have read, understood and agree to abide by the Code of Conduct for Pharmacists as published by the PSI and as may be updated from time to time.
10. I declare that I have not been prohibited under the law of another state from carrying on any activity in that state corresponding to the practice of a pharmacist or the carrying on of a retail pharmacy business, or convicted in Ireland or another state of an offence the nature of which has, in the opinion of the Council, a bearing on my fitness to practice.
11. I declare that I have not been prohibited from carrying on any practice, profession or occupation which mainly consists of the provision of health (including animal health) care or services or social care or services in Ireland or any other country.
12. I am not an undischarged bankrupt, according to the laws of Ireland or any other country.
13. I declare that I am not aware of any reason on grounds of physical or mental health why I might be unable to discharge the responsibilities of a registered pharmacist if so registered.
14. I declare that there is nothing in my past history, conduct or character that, having regard to patient (including animal health) safety and public health, would render it unsafe for me to be permitted to undertake the practice of pharmacy in Ireland.
15. I am aware that under Section 6 of the Statutory Declarations Act 1938 (as amended) it is in Ireland a criminal offence punishable by fine and/or imprisonment for a person to swear a Statutory Declaration which contains information that is to their knowledge false or misleading.

## **STATUTORY DECLARATION FORM**

I make this solemn declaration conscientiously believing the same to be true for the benefit of the Pharmaceutical Society of Ireland by virtue of the Statutory Declarations Act 1938 (as amended).

**DECLARED** before me

\_\_\_\_\_

*[insert name in capitals]*

a Notary Public / Commissioner for Oaths/Peace Commissioner/Practising Solicitor

**BY**

\_\_\_\_\_

*[insert name of the person (applicant) swearing the declaration in capitals here]*

who is personally known to me or who was identified to me

\_\_\_\_\_

*[insert name of identifying person here]*

**OR**

whose identity has been established to me before the taking of this Declaration by the production to me of passport no.

\_\_\_\_\_ issued on \_\_\_\_\_ by the authorities of

\_\_\_\_\_ *[which is an authority recognized by the Irish Government]*

**OR**

national identity card no. \_\_\_\_\_ issued on \_\_\_\_\_ by the

authorities of \_\_\_\_\_ *[which is an EU Member State, the Swiss Confederation or a Contracting Party to the EEA*

Agreement]

**AT**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*[insert address at which declaration was sworn here]*

in the County/City of \_\_\_\_\_

This \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF APPLICANT**

\_\_\_\_\_  
**SIGNATURE OF PERSON AUTHORISED TO  
TAKE DECLARATION**

## PAYMENT OF APPLICATION FEE – NATIONAL ROUTE OF REGISTRATION

1. Please complete the section(s) below, and enclose the relevant fee with your application.

Fee for First Registration: €540.00

Fee for Re-Registration: €870.00

2. Please note your application will not be processed if the fee is not submitted at time of application.

<b>Applicant's Full Name</b>	
<b>Payment Method (please tick as appropriate)</b>	<ul style="list-style-type: none"><li>Postal Order/Bank Draft (please attach) <i>Made payable to The Pharmaceutical Society of Ireland</i> <input type="checkbox"/></li><li>Credit/Debit Card (complete section below) <input type="checkbox"/></li></ul>

Card Payment Details		
<b>Card Type</b>	Visa <input type="checkbox"/>	MasterCard <input type="checkbox"/>
<b>Cardholder Name</b>		
<b>Card Number</b>		
<b>Expiry Date</b>		
<b>Security Code</b>		
<p>I authorise the PSI to charge the above card with the following amount (please tick):</p> <p>€540 <input type="checkbox"/></p> <p>€870 <input type="checkbox"/></p> <p><b>Signature of Cardholder:</b> _____ <b>Date:</b> _____</p>		